

CRITERIA FOR PRIOR AUTHORIZATION**Calcitonin Gene-Related Peptide (CGRP) Antagonists****PROVIDER GROUP:** Pharmacy**MANUAL GUIDELINES:** All dosage forms of the following medications will require prior authorization.

Erenumab-aooe (Aimovig™)

Fremanezumab-vfrm (Ajovy™)

CRITERIA FOR INITIAL APPROVAL: (must meet all of the following)

- Patient has a diagnosis of chronic or episodic migraine
 - Chronic migraine: 15 or more headache days per month, for more than three months, which, on at least eight days/month, has the features of migraine headache
 - Episodic migraine: less than 15 headache days per month
- Patient must have experienced an inadequate response to a trial of two or more preventive therapies after titration to maximum tolerated doses (trial of at least 60 days), OR have a documented intolerance or contraindication to two or more preventive therapies. Preventive therapies include but are not limited to beta-blockers, calcium channel blockers, anticonvulsants, and antidepressants
 - Prescriber must provide documentation of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication).
- Prescriber must attest that all medication-specific safety criteria, as defined in table 1, is met.

CRITERIA FOR RENEWAL:

- Prescriber must attest that all medication-specific safety criteria, as defined in table 1, continues to be met.
- The patient must meet one of the following:
 - The patient has experienced a reduction in the number of monthly headache days compared to baseline (prior to starting treatment with the requested agent)
 - The patient has experienced a reduction in the number of monthly headache days of at least moderate severity compared to baseline (prior to starting treatment with the requested agent)

LENGTH OF APPROVAL: 6 months**TABLE 1. MEDICATION-SPECIFIC CRITERIA**

MEDICATION-SPECIFIC CRITERIA	
Ajovy™ (fremanezumab-vfrm)	<ul style="list-style-type: none"> • Patient must be ≥ 18 years of age • Dose must not exceed either 225 mg (1.5 mL/1 syringe) per month OR 675 mg (4.5 mL/3 syringes) every 3 months
Aimovig™ (erenumab-aooe)	<ul style="list-style-type: none"> • Patient must be ≥ 18 years of age • Dose must not exceed 140 mg (2 mL/2 syringes) per month

APPROVED PA Criteria

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

DATE

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE